DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PROPOSED

PUBLIC NOTICE

Nursing Facility Quality Assessment

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Title XIX Medicaid State Plan regarding *Nursing Facility Quality Assessment*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by July 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposed amends the Title XIX Medicaid State Plan to implement a nursing facility quality assessment fee, also known as a nursing facility provider tax, effective June 1, 2012.

Statutory Authority

- Social Security Act §1902(a)(13)(A), *Public process for determination of rates of payment;*
- 42 CFR §§433.55 through 433.74, *Health Care-Related Taxes;*
- 42 CFR §440, Subpart A, *Definitions*;
- 42 CFR Part 447, Subpart C – *Payment for Inpatient Hospital and Long-Term Care Facility Services*;
- 42 CFR §447.205, *Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates*

Background

Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (P.L. 102-234) in 1991, amending Section 1903(w) of the Social Security Act (42 USC §1396b(w)). Those laws were later revised through the Tax Relief and Health Care Act of 2006 (P.L. 109-432). These laws, along with corresponding federal regulations (42 CFR §§433.54 through 433.74), provide the authority and guidelines that states must follow in order to fund a portion of the state share of Medicaid program costs by assessing/taxing health care providers or services. The federal authority for health care-related taxes is the Centers for Medicare and Medicaid Services (CMS).

Federal law permits states to collect revenues or “health care-related taxes” from nineteen (19) specified classes of health care providers or services. Revenues collected from health care-related taxes can be used to raise provider rates, fund other costs of the Medicaid program or be used for other non-Medicaid purposes, such as depositing the funds into the state’s general treasury. States must meet strict federal requirements when implementing health care-related taxes, including taxing all providers or services in a class (i.e., the tax cannot be limited to Medicaid providers only) and applying a methodology that is similar for all providers or services in that class (i.e., same rate or amount of tax is applied).

Health care-related taxes are fees, assessments or other mandatory payments related to:

(1) Health care items or services;

(2) Provision of, or authority to provide, health care items or services; and,

(3) Payment for health care items or services.

In order to be permissible under federal law, any provider tax enacted by a state must be (1) broad based, (2) uniformly imposed and (3) cannot violate hold harmless provisions.

Summary of Proposal

Nursing facility services are a mandatory Medicaid state plan service. Delaware Medicaid’s reimbursement policy establishes eight levels of care within nursing facilities based on patient acuity with up to three “add-ons” for additional services required by nursing facility residents as determined by Division of Medicaid and Medical Assistance (DMMA)

nurses. Facility-specific per diem rates are computed annually based on annual facility cost reports. Because of potential budget shortfalls caused by the nation's poor economy, nursing facility Medicaid rates have been frozen since April 1, 2009 at the level they were as of December 31, 2008.

With approval of the Centers for Medicare and Medicaid Services (CMS) of a Title XIX State Plan amendment that will be submitted before June 30, 2012, effective for services provided on or after June 1, 2012, DMMA intends to modify reimbursement for nursing facility services provided under the Medicaid program by increasing the nursing facility per diem amounts for each facility by an amount computed annually that will use proceeds of a nursing facility provider tax to fund the state share of the increased per diem rates. The implementation of this increase in per diem payments is contingent upon passage by the Delaware General Assembly of legislation that defines the applicability of the Nursing Facility Quality Assessment provider tax.

In compliance with 42 CFR §447.205, Public Notice was published before the proposed effective date of the change on May 30, 2012 in the *News Journal* and on May 31, 2012 in the *Delaware State News*.

Fiscal Impact Statement

DMMA estimates that the proposed amendment to the Medicaid State Plan is expected to increase payments to nursing facilities by approximately $29 million in State Fiscal Year 2013 but will require no increase in spending from the General Fund because the state share of the increased claims will be funded by the proceeds of the Nursing Facility Quality Assessment Fund currently under consideration by the Delaware General Assembly.

DMMA PROPOSED REGULATION #12-28
REVISIONS:

ATTACHMENT 4.19-D
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: **DELAWARE**
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

Payment Methodology for Rate Periods Beginning January 1, 2009:

A. Notwithstanding any other provision of this section, the following adjustments will apply to reimbursement rates for all long term care facilities, except for state owned and operated facilities.

B. Effective for dates of service on or after April 1, 2009, per diem rates for long term care facilities will be adjusted to the rates that were in effect on December 31, 2008. However, if Delaware has in effect a nursing facility quality assessment fee applicable to assessment periods beginning on June 1, 2012 and thereafter, the per diem rates for long term care facilities computed for the period ending December 31, 2008 shall be increased by a Quality Assessment Rate Adjustment Amount as follows:

Except as excluded in section (c) below, each nursing facility's rates shall be increased for dates of service beginning on or after June 1, 2012 by a per day dollar amount equal to the sum of:

(a) a per day dollar amount equal to the per day dollar amount of the Nursing Facility Quality Assessment Fee that will be owed for the upcoming rate year by each facility as specified in Delaware Code Title 30, Chapter 65 section 6502 (b) and (d), plus

(b) a per day dollar amount computed as follows:

Step 1. Obtain the total annual Medicaid patient days for all participating nursing facilities from the Delaware Medicaid nursing facility cost reports for the fiscal year ending June 30 of the previous year for each facility, excluding government-operated and pediatric nursing facilities. Sum the Medicaid patient days for each facility to compute the total aggregate statewide Medicaid patient days.

Step 2. For each facility identified in Step #1, multiply the per day dollar amount of the Nursing Facility Quality Assessment Fee that will be owed per paragraph B. (a) above by each facility times the number of Medicaid patient days for each facility from Step #1. Sum the dollar amounts for all facilities to compute the aggregate statewide total annual assessment amount to be paid to the facilities.

Step 3. Obtain the Total annual patient days and non-Medicare patient days for the fiscal year specified in Step 1 from each of the facilities that will be subjected to the quality assessment specified in paragraph (a) above for the upcoming State fiscal year for both Medicaid and non-Medicaid nursing facilities licensed to operate in Delaware.

Step 4. For each facility identified in Step #3, multiply the per day dollar amount of the nursing facility quality assessment fee that will be owed by each facility as specified in Delaware Code Title 30, Chapter 65 section 6502 (b) and (d) times the number of non-Medicare patient days for each facility from Step #3. Sum the dollar amounts for all facilities to compute the statewide total aggregate annual dollar amount of the assessment.

Step 5. Multiply the aggregate assessment computed in Step #4 by 0.9.

Step 6. Determine the total computable funding amount using the assessment amount from Step 5 as the state share at the applicable FMAP (and any other allowable Federal match) for the payment period.

Step 7. Subtract the Medicaid portion of the assessment computed in Step #2 from the total computable payment amount computed in step #6.

Step 8. Divide the dollar amount computed in step #7, by the statewide aggregate patient days from Step #1 to compute a per day dollar amount to be added to (a) above.

(c) The following Long Term Care nursing facilities are excluded from the quality assessment rate adjustment amounts computed in (a) and (b) above:

- government-owned nursing facilities,
- facilities that exclusively serve children,
- facilities with no Medicaid patients,
- facilities that are subject to penalties under Delaware Code Title 30, Chapter 65 section 6503 for dates of service in the months that penalties apply,
- facilities not located within the State of Delaware,
- all nursing facilities are excluded from this Quality Assessment Rate Adjustment Amount if the State of Delaware does not implement or if implemented, subsequently terminates, a nursing facility quality assessment fee

C. Future rate adjustments will be suspended until further notice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE:**DELAWARE**
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

I. General Provisions

A. Purpose

This plan establishes a reimbursement system for long-term care facilities that complies with federal requirements, including but not limited to:

- Requirements of the Omnibus Reconciliation Act of 1981 that nursing facility provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility.
- The requirement that Medicaid payments in the aggregate do not exceed what would have been paid by Medicare based on allowable cost principles.
- Limitations on the revaluation of assets subsequent to a change of ownership since July 18, 1984.

- Requirements of the Omnibus Reconciliation Act of 1987 to establish one level of nursing care, i.e., Nursing Facility Care, to eliminate the designation of Skilled and Intermediate Care, and to provide sufficient staff to meet these requirements.
- The requirement to employ only nurse aides who have successfully completed a training and competency evaluation program or a competency evaluation program.

B. Reimbursement Principles

1. Providers of nursing facility care shall be reimbursed prospectively determined per diem rates based on a patient based classification system. Providers of ICF-MR and ICF-IMD services shall be reimbursed prospectively determined per diem rates.